RAIDR

Rapid Actionable Insight Driving Reform

necs

NHS

What is RAIDR?

RAIDR is one of the UK's leading health intelligence and risk stratification tools, covering nearly 1,000 GP practices, circa 20 places and a population of 8 million.

Developed in collaboration with commissioners, providers, GPs and practice staff to provide a single portal to help improve data quality and ultimately patient outcomes, RAIDR enables you to navigate, select and drill down to gain valuable insight, showing high level trends all the way down to detailed patient level data.

Continually evolving, RAIDR's suite of intuitive dashboards provides an end-to-end population health management solution, tackling health inequalities in addition to helping organisations meet targets as set out in local and national incentive schemes.

RAIDR puts you in total control, with all the information you need at your fingertips

"At NECS, we're very proud of our award-winning Business Intelligence tool, RAIDR, which delivers real-time data, powerful dashboards and flexible reporting to improve patient outcomes."

Ian Davison
Business Information Services Director
NECS

Award-winning innovations

NECS has created digital applications to improve efficiency, link the power of data and solve the most complex problems in health and social care.

Our team of software developers and data engineers work alongside our subject matter experts to create digital solutions that are powerful yet intuitive and interoperable.

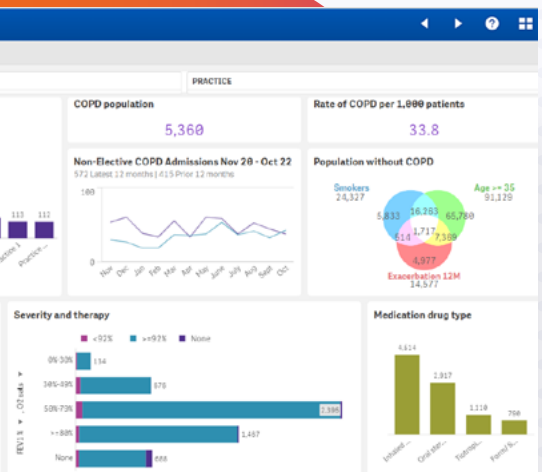
BRIGHT IDEAS IN HEALTH AWARDS 2022 FINALIST

HSJ PATIENT SAFETY AWARDS 2023
WE ARE PROUD TO BE A FINALIST
PATIENT SAFETY IN ELECTIVE RECOVERY AWARD

Primary Care

Certified as a Class I medical device, our Primary Care dashboard is refreshed monthly with data collated from GP clinical systems to provide ICBs, Providers, Primary Care Networks (PCNs) and GP practices with the information they need to improve data quality and more importantly, patient outcomes.

- Presents data at both aggregate and patient identifiable (PID) levels, enabling clinical cohort analysis with case finding capabilities and built in risk stratification.
- Can be utilised to optimise Quality Outcome Framework (QOF) registers to improve outcomes for individual patients.
- Inclusion of Index of Multiple Deprivation (IMD) decile filters supports effective targeting of patients across a system and enables view of prevalent long term conditions in each area, as well as the demographic make-up of the population (gender, age, ethnicity).



Patient Activity

Our Patient Activity dashboard utilises multiple datasets to provide a breadth of information on secondary care activity, including Inpatient, Outpatient, A&E, 111, 999 and community services to provide a comprehensive view of what is happening with your patient population outside of primary care.

- Aggregate level allows users to effectively benchmark and interrogate trends across the system while RAIDR's patient identifiable layer of the dashboard looks to enhance individual care. Data is available to view from the latest three financial years and displays costs in addition to activity.
- Identifies high intensive users of these services to ultimately improve patient pathways and ensure the appropriate care is being provided. Also identifies vulnerable individuals, such as those suffering from poor mental health or who may have substance or alcohol misuse issues.
- Developed to address health inequalities as viewed through the Core20Plus5 lens with the ability to filter patients in terms of age, gender, ethnicity and areas of deprivation.
- Re-identifies pseudonymised NHS numbers to allow users to export the data out and directly into your GP clinical system, supporting key population health work within the community.

Population Health

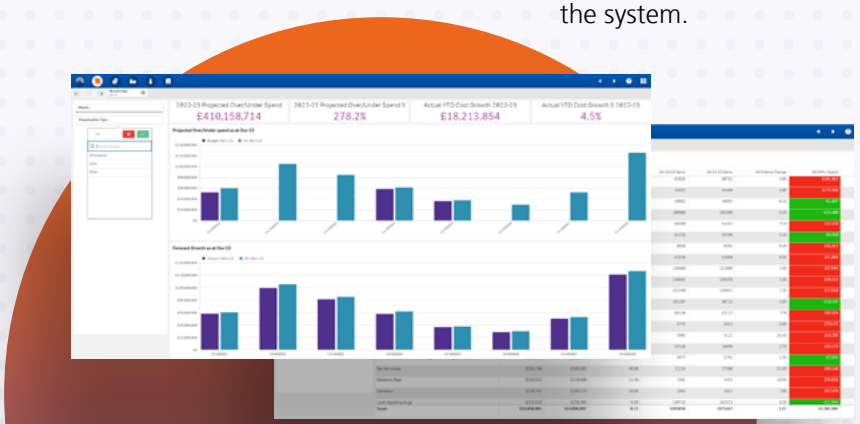
Our Population Health dashboard was developed to enable health organisations in their aims to improve the physical, mental and socioeconomic outcomes of their patient population. Bringing data to life with interactive, intuitive visualisations, Population Health provides a system level view of an entire populations health needs with the ability to drill down to GP practice level.

- Facilitates proactive case management and effective targeting of at-risk individuals across the system. Viewing the data via the lens of Core20Plus5, areas of deprivation can be compared to address health inequalities across regions and select distinctive population segments to see the population makeup of gender, age and whether or not there are lifestyle risk factors.
- Key features include multiple population segmentation models, built in risk stratification tools and interactive mapping.
- Provides the information you need at the right time to ask the right questions.

Prescribing

Our Prescribing dashboard utilises EPACT2 data to inform effective decision making while supporting broader population health management workstreams.

- Offers access to monthly prescribing budget positions at ICB, place, PCN and GP practice levels in addition to enabling the monitoring and maximising of engagement scheme achievement. Indicators displayed within the screens are part of the Quality Improvement Project (QIP) and have been integral to analysing progress over specific time frames.
- Successfully used by medicine optimisation teams to target GP practices which have higher prescribing costs and to begin meaningful discussions on how to reduce these pressures.
- Tracking high-cost drugs spend, Prescribing supports ASTRO-PU weighted analysis using local and national benchmarking indicators. Also focuses on personally administered controlled drugs to ensure prescribing is safe, cost effective and appropriate across the system.



Waiting Well

Tackling the elective waiting list backlog is one of the key priorities for health and social care with over 6.8 million people currently on the waiting list in England. A need was identified to target patients with potential risk factors or who required support managing their long term conditions. This would then ensure that those patients would be fit for their intended procedure when the time came and they were 'waiting well'.

- Our Waiting Well dashboard collates data monthly from primary care and combines this with the weekly minimum elective waiting list dataset to provide ICBs, PCNs, practices and Provider Trusts with the tools to effectively target and manage individual patients.
- A unique solution which benefits both patient and clinician while reducing unnecessary costs.
- Organisations can offer tailored support to individuals based on their need and to encourage self-care with lifestyle improvements and remote monitoring. To address health inequalities through the lens of Core20Plus5, the data can be filtered to focus on patients residing in areas of deprivation as well as age, gender and ethnicity.

Bespoke Dashboards

We work closely with our customers to collaborate and develop bespoke digital solutions to meet their needs.

Primary Care Network (PCN)

- Supports your organisation whether that be at system, place or practice level to achieve targets set out within national incentive schemes such as the Direct Enhanced Service (DES) with dedicated screens for each Impact & Investment Fund (IIF) indicator.
- Provides a single source of information to inform effective decision making, implement proactive care plans and reduce workload.

Severe Mental Illness (SMI)

- Improves the visibility of mental health checks across the population. The ability to view this data on a monthly basis rather than awaiting nationally produced figures provides timely and accurate data to those that need it.
- Information is provided based on the SMI cohort – showcasing a birds-eye view across the system with the functionality to perform benchmarking and trend analysis against the non-SMI population in terms of long-term condition prevalence, alcohol usage and obesity levels.

Learning Disabilities

- Utilises data extracted monthly from GP practices to provide a single view of clinical activity across the system for your Learning Disability population, with the ability to compare against your non-Learning Disability population and to ensure that the care being provided is equitable.

Bespoke dashboards are available upon request and may incur additional charges. Find us on **Digital Marketplace G-Cloud.**

Testimonials

"Obesity is a serious health concern which increases the risk of many other conditions, including type 2 diabetes. At Leeds, we utilised RAIDR's Primary Care dashboard to support our weight management programmes.

With just a few clicks we could look at population prevalence in relation to high BMI and related long-term conditions and then drill down to patient level data showing clear NHS numbers. A great feature of the dashboard that PCNs found invaluable was the ability to create and define specific cohorts of patients who fell into these categories, which led to individuals being identified who required enhanced care plans."

Data Quality Officer, Leeds

"RAIDR's suite of dashboards provides me with monthly access to a range of datasets brought together in one place. As a clinician, I can use this information to improve outcomes for patients with multiple long term conditions. RAIDR's built in risk stratification tools also help me target those most at risk of hospital admission, enabling quick and effective intervention."

GP, Northumberland

"Using RAIDR's Primary Care dashboard, in just a few clicks I was able to quickly identify nine patients with potential AF who weren't being treated, I emailed staff in practice to check out these patients. Very soon afterwards their reply indicated that five could be discounted e.g. they had declined treatment, or the condition had resolved etc. but the remaining four are four potential lives saved. It's not very often I can have that sort of impact in 30 minutes!"

GP, Co Durham

"Our team have monthly Community Disciplinary meetings with GP Practices, and it was agreed that we would look to identify frequent A&E attenders from the surgeries we cover, to ensure we do not have patients making unnecessary visits to the service. Each month, I report on any patients that have attended A&E 5 times or more and use RAIDR's Patient Activity dashboard to do this via the A&E Frequent Users screen.

Should we have frequent attenders that did not require any urgent attention but are repeatedly visiting, we discuss these patients at the meeting and look into alternative support for them within our community teams that may prevent them from re-attending."

Care Co-ordinator, Derby & Derbyshire

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